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The overlap between psychiatric symptoms and challenging behaviour: A preliminary study

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ABSTRACT

Increasingly, challenging behaviour is explained by way of psychiatric symptomatology. This poses possible pitfalls. First, the possibility exists that both psychiatric symptoms and challenging behaviour are concurrent expressions of common underlying factors. Second, psychiatric symptoms may be rated as present on the basis of challenging behaviour, which may render it more difficult to explain the latter by way of the former. The present study was conducted in order to investigate possible overlaps between psychiatric symptoms and challenging behaviour, when symptoms are rated by caregivers. The results indicate considerable overlaps. Implications for explaining challenging behaviour are discussed, as well as limitations of the study, first and foremost the use of untrained assessors and small sample size.

1. Introduction

Explaining challenging behaviour is important in order to prevent and treat it. In addition to behavioural, functional explanations (e.g. Pelios, Morren, Tesch, & Axelrod, 1999), one major approach is to explain challenging behaviour by way of psychiatric symptomatology (e.g. Pyles, Muniz, Cade, & Silva, 1997). In relation to the latter, studies show associations between psychiatric disorders and challenging behaviour. Moss et al. (2000) found that symptoms of depression and hypomania identified via the PAS-ADD checklist were significantly associated with challenging behaviour. Holden and Gitlesen (2003) found especially anxiety and psychotic symptoms to be associated with

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challenging behaviour, and Rojahn, Matson, Naglieri, and Mayville (2004) demonstrated that psychopathology in general was associated with self-injurious, aggressive, destructive and stereotyped behaviours. Finally, Hemmings, Gravestock, Pickard, and Bouras (2006) found affective symptoms to be related to self-injury, and to some extent to aggression, while screaming and destructive behaviours were more associated with autism-related social impairment, than with traditional psychiatric symptoms. In summary, findings are somewhat mixed. Because relationships are based on group studies, they are necessarily rather general. Moreover, correlations hardly explain anything. In fact, in some studies it is emphasized that the issue of cause and effect is not addressed (Hemmings et al., 2006; Holden & Gitlesen, 2003; Reiss & Rojahn, 1993).

As far as explaining challenging behaviour by way of psychiatric symptomatology is concerned, one problem is that "Psychiatric symptoms and challenging behaviour might be two labels of the same phenomena" (Holden & Gitlesen, 2003, p. 331). This may explicitly be the case when diagnoses are based on 'atypical symptoms', or 'behavioural equivalents', including challenging behaviour (e.g., Meins, 1995; Rojahn, Borthwick-Duffy, & Jacobson, 1993). Aggression, irritable mood, self-injury, and screaming have been interpreted as depression, (Emerson, Moss, & Kiernan, 1999; Lowry, 1993), cyclical problem behaviour as a mood disorder (Emerson et al., 1999), being easily provoked into outbursts of anger as mania (Lowry, 1993), and repetitive self-injury as compulsions (Bodfish et al., 1995). A major reason for this diagnostic practice has been that people with especially severe and profound intellectual disability are less able to express classic symptoms. The practice has been criticized for contributing to false positive diagnoses, especially depression (McBrien, 2003; Tsiouris, Mann, Patti, & Sturmey, 2003), and for its 'tautological rationale', that is, employing atypical symptoms to diagnose individuals who subsequently participate in studies exploring how disorders manifest themselves (Ross & Oliver, 2002). Anyway, the more psychiatric symptoms are reported on the basis of challenging behaviour, the more difficult it becomes to explain the latter by way of the former. Stated another way, once a challenging behaviour is thought of as a psychiatric symptom it can hardly be considered as secondary to that symptom.

In the present study, we are concerned with possible overlaps between symptoms and challenging behaviour, when diagnoses are not meant to be based particularly on atypical symptoms. In our opinion, descriptions of some psychiatric symptoms may overlap with challenging behaviour. Several items on for example the PAS-ADD checklist (Moss, 2002), a widely used psychiatric screening instrument, may concurrently describe challenging behaviour: 'Restlessness or pacing, unable to sit still' may be rated as present on the basis of repetitive, self-injurious behaviour. Several symptoms may be aggressive, self-injurious or destructive behaviour, such as 'Irritable or bad tempered', 'Suspicious, untrusting, behaving as if someone is trying to harm them or is talking about them', 'Sudden intense fear or panic triggered by situations or things, such as being alone, crowds, thunder, etc.', and 'Fearful or panicky (not triggered by situations or things)'. 'Loss of appetite and enjoyment of food' may be severe food refusal, and 'Increased appetite, over-eating', in extreme forms, may also be challenging behaviour in itself. 'Avoids social contact more than usual for the person', could be rated as present if the person shows escape-motivated aggression of self-injury. 'Odd gestures and mannerisms' may be several types of challenging behaviour, and 'Odd or repetitive use of language' could be for example screaming or pestering. The examples are only meant as possibilities. Similar examples can be drawn from instruments such as DASH-II (Matson, 1995), PIMRA (Matson, Kazdin, & Senatore, 1984), and Reiss Screen for Maladaptive Behaviour (Reiss, 1987).

In relationship to the collection of information regarding psychiatric symptoms, some studies on the association between psychiatric symptoms and challenging behaviour have employed trained assessors (Hemmings et al., 2006; Rojahn et al., 2004). Other studies have employed untrained caregivers (Holden & Gitlesen, 2003; Moss et al., 2000). In both cases, at least some symptoms may have been reported on the basis of challenging behaviours to a smaller or larger extent. All in all, we should have known more about the observational basis for rating symptoms. An initial step in order to investigate possible overlaps between psychiatric symptoms and challenging behaviour may be to ask caregivers what they have observed when they rate symptoms as present on screening instruments. The aim of the present study was therefore to investigate whether caregivers, not especially trained in psychiatric assessment, rate psychiatric symptoms as present on the basis of challenging behaviour, and, if this is the case, to what extent.